# Dutch anti-alcohol campaign is under attack

The powerful Dutch drinks industry has demanded that a hard hitting antidrinking poster campaign linking excess alcohol consumption with images of violence and ill health be halted.

Already one poster entitled Champagne Brut, depicting a sobbing and distressed young woman, has been withdrawn from hundreds of locations for "political reasons." Health minister Professor Borst-Eilers called for the poster to be withdrawn after complaints from the French ambassador about the use of the word champagne in this way.

Now STIVA, the foundation for responsible use of alcohol, an umbrella group representing producers and importers of alcoholic drinks including such names as Heineken and Grolsch, want the remaining three posters withdrawn. It argues a government backed campaign should not discredit particular types of product.

Professor Borst-Eilers has refused to restrict the campaign further. Public health officials fear that the degree of heavy drinking among 16 to 25 year olds in the Netherlands is increasing.

The government funded campaign, with its slogan "Drinking can break your heart," is run by the independent national institute for health promotion and disease prevention. Campaign leader Wim van Dalen explained that exaggerated images were necessary to communicate the message because, unlike drugs, young people saw drinking alcohol as normal. This campaign is intended to emphasis the connection between drinking and domestic violence and to show the consequences of excess drinking unequivocally.

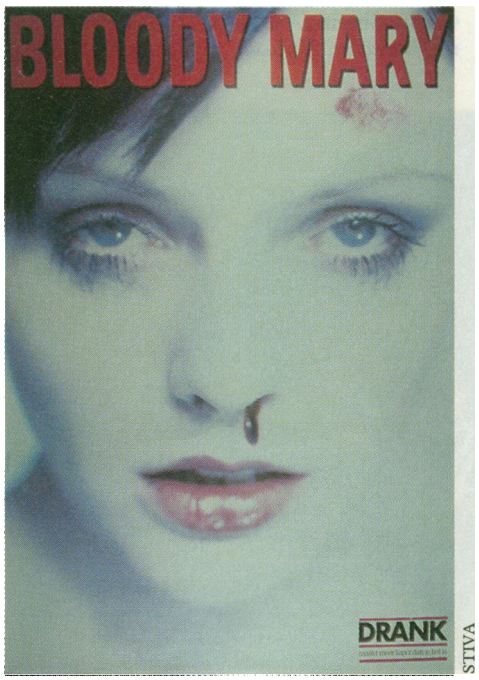
The remaining posters are Bloody Mary, showing a woman with a bleeding nose; Cola Tic, showing a young man with a black eye; and Witbier [White Beer], showing a deathly pale teenager with a hangover.

Sandra van Ginneken of the Ministry of Health's alcohol education project said that campaigns to promote moderate drinking among 16 to 25 year olds had reduced the proportion of heavy drinkers from 18% to 13% since 1986. But within this group the average consumption had increased from 24.9 to 26.3 glasses per week.

Mr van Dalen said: "One of our main problems is young people drinking to excess at weekends."

In total, addiction clinics treated more than 22 000 alcoholics in 1994 out of a population of 15.6 million.

The STIVA director, Khee Liang Phoa, argued that cooperation between the industry and government to promote moderation in drinking through education and marketing is seen as a model in the Netherlands and abroad. But STIVA object to a campaign that discredits particular products. The problem was not the drink but its misuse, he argued.—TONY SHELDON, *medical journalist, Utrecht*



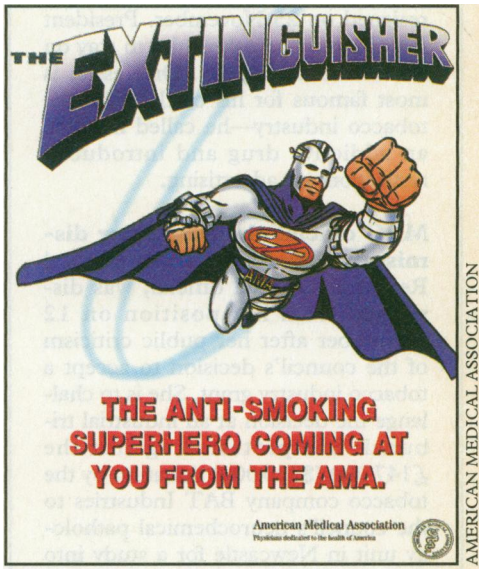

*The posters stress the link between drinking and violence*

# Joe Camel beware as doctors strike back

The American Medical Association has launched a Superman-like cartoon hero, the Extinguisher, whose mission is to educate young children about the dangers of smoking before they start. The association hopes the campaign will rival those of cigarette manufacturers, which are increasingly targeting advertising at the young.

Smoking rates among the young continue to rise in the United States and are at their highest for 16 years. Six year olds are more familiar with the character advertising Camel cigarettes—Old Joe Camel—than with Mickey Mouse, according to a 1991 study published in *JAMA*.

"More than three thousand young people start to smoke every day. One third of them will die from their addiction. Young smokers start at age 13, they become daily smokers at age 14. Close to 35% of teens smoke, a significantly higher percentage than adults. It's truly an epidemic among our youth," said Brian Ruberry, spokesperson for the National Center for Tobacco-Free Kids, which is cooperating with the association in its campaign.




*The campaign aims to make not smoking look cool*

The teenagers who start smoking each day replace older smokers who die or stop smoking, and they choose the brands that advertise to children. When the Joe Camel character was introduced Camel cigarettes' market share among teenagers rose from 3% to 13%, according to the Initiative on Tobacco Marketing to Children. Some 90% of adult smokers begin by the age of 18. Although it is illegal to sell tobacco products to minors in every state, they are widely available.

The association's Extinguisher, who has already appeared on several national television shows, is portrayed as a young loser who was on the brink of death from smoking. His savvy physician, Dr Nola Know, who also appears in the campaign, brought him back to life and turned him into a scientific wonder with heat seeking devices that detect cigarettes from miles away.

The campaign is tied in with *Scholastic News*, a current events magazine that is distributed to about four million elementary school children in 150 000 American classrooms. Children will work on a "Tobacco-Free Pledge Contest," explaining how they plan to help in the fight against smoking and keep their friends, schools, and communities tobacco free. The association is also working with the Discovery Zone, a group of indoor adventure playgrounds where American parents and their children play games and participate in interactive learning activities in inclement weather.—JANICE HOPKINS TANNE, *medical journalist, New York*

## *In Brief*

**Commissioner of US FDA resigns:** Dr David Kessler, widely regarded as the most active and most controversial commissioner of the Food and Drugs Administration, resigned on 25 November. President Bill Clinton had asked him to stay on for another four years. Dr Kessler is most famous for his battles with the tobacco industry—he called nicotine an addictive drug and introduced restrictions on advertising.

**MRC official challenges her dismissal:** Mary Rice, a senior Medical Research Council official, was dismissed from her position on 12 November after her public criticism of the council's decision to accept a tobacco industry grant. She is to challenge the decision at an industrial tribunal. She protested against the £147 000 ($220 000) donation by the tobacco company BAT Industries to the council's neurochemical pathology unit in Newcastle for a study into the effects on nicotine on Alzheimer's disease.

**Genetic research opens possibilities in Duchenne muscular dystrophy:** Professor Kay Davies and colleagues from the University of Oxford have found that the protein utrophin can reduce the muscle wasting and weakening symptoms of Duchenne muscular dystrophy in mice. The research suggests that it may be possible to substitute utrophin for the malfunctioning gene dystrophin in the muscles of boys affected by the disease (*Nature* 1996:**384**:349-53).

**US has highest rate of sexually transmitted disease in developed world:** A report from a the Institute of Medicine found that gonorrhoea infects 150 out of every 100 000 people in the United States compared with 3 out of 100 000 in Sweden and 18.6 in 100 000 in Canada. A quarter of the estimated 12 million new cases that occur each year are adolescents.

**British pill scare caused needless panic:** A report by the Birth Control Trust concluded that government warnings in October 1995 that women using "third generation" pills should change to other brands was unnecessarily alarmist and out of step with the assessment of medical information made by authorities in other countries. New government figures show the scare led to around 3000 extra abortions in the United Kingdom.

# US sets new priorities for liver transplants

The United States has announced a major shift in the way that waiting lists for liver transplantations are organised so that patients with acute liver failure will get priority over those with chronic conditions such as alcoholic liver disease, hepatitis B and C, and liver cancer. The decision has sparked controversy as most chronic liver conditions are associated with high risk behaviours, and rationing in this way could therefore imply a moral judgment.

The United Network for Organ Sharing, the organisation that maintains the national registry of donor organs and the waiting list, says that it has authorised the new rationing system to favour those patients who have the best prospects for survival rather than those who may have been on the waiting list longer but have a worse overall prognosis.

In 1995 only 3922 people out of the 7279 on the waiting list received a liver transplant and 522 people died while waiting. Patients who develop acute liver failure usually have fewer comorbidities than those with chronic liver disease and therefore generally fare better with the transplants. The policy shift is predicted to save about 200 livers as there will be less need for retransplantation.

Historically, transplant priority was determined by a regional ranking system in which those who were the most ill and had been on the waiting list the longest took precedence over those who were newly ill. The patients who are the highest priority are designated as "status 1." The new rules, scheduled to take effect on 20 January 1997, will assign this highest status to patients with sudden liver collapse from such causes as mushroom poisoning, Reye's syndrome, and exposure to hepatotoxins.

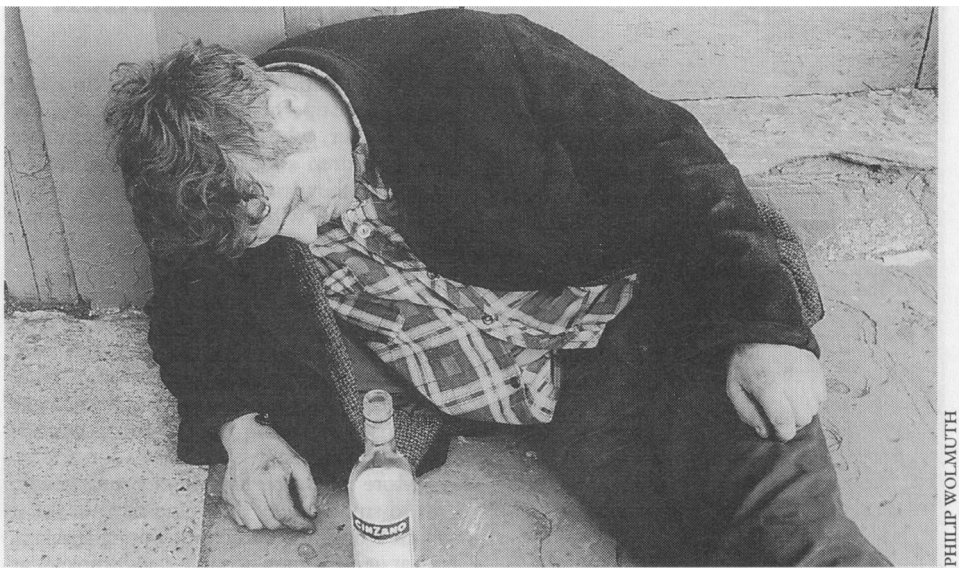
Status 1 will also be assigned to children with liver failure of any cause and to liver transplant recipients whose donor organs have failed within one week of transplantation. Children will be given this higher status because they generally do well with transplants and also because with their fragile blood-brain barrier they are at risk of kernicterus or damage to the central nervous system from liver failure.

Walter Graham, executive director of United Network for Organ Sharing, disputes the contention that the rationing change is an attempt to deny livers to people dependent on alcohol. He maintains that transplant priority is based on medical criteria and not moral judgments. According to Mr Graham, patients with acute liver failure currently receive a mere 3.3% of all liver transplants. Under the new policy that number will increase to 4.4%. This still leaves 95% of transplants to those with chronic liver failure. He said that patients with acute hepatic failure have the greatest need as they die quickly, within hours or days. That acutely ill patients survive transplantations better was a secondary consideration, he added.

Some surgeons, however, refute this assessment. Dr Charles Miller, a transplant surgeon at Mount Sinai Medical Center in New York, said: "It hasn't been demonstrated that acute patients do better than chronic—it depends on who and where you are." Indeed, some experts maintain that the revised regulations do not go far enough in revamping organ allocation protocols, as they do not address regional disparities in the availability and procurement of organs.

In both the old and the new regulations, lists of potential transplant recipients are matched with donors by locality—first by city, then by region, and finally nationally. And some states have more centres and greater availability of organs for transplant than others, so where people live affects their chances of getting a transplant.

The rationing controversy has caused such an uproar that the Department of Health and Human Services is convening a public forum, to be held at the National Institutes of Health, on 10 and 11 December to discuss these issues and could decide to supersede the policy of United Network for Organ Sharing.—DEBORAH JOSEFSON, *medical journalist, Norwalk, Connecticut*




PHILIP WOLMUTH

*Patients with alcoholic liver disease will go to the bottom of the list for liver transplants*

# Fears over Ebola spread as nurse dies

A South African nurse, Marilyn Lahana, has died in Johannesburg after contracting the Ebola virus while caring for an infected Gabonese doctor at a private Johannesburg hospital. The death has prompted fears of a spread of the Ebola virus in South Africa. About 350 people, including health care staff, are being monitored in Johannesburg for signs of the disease.

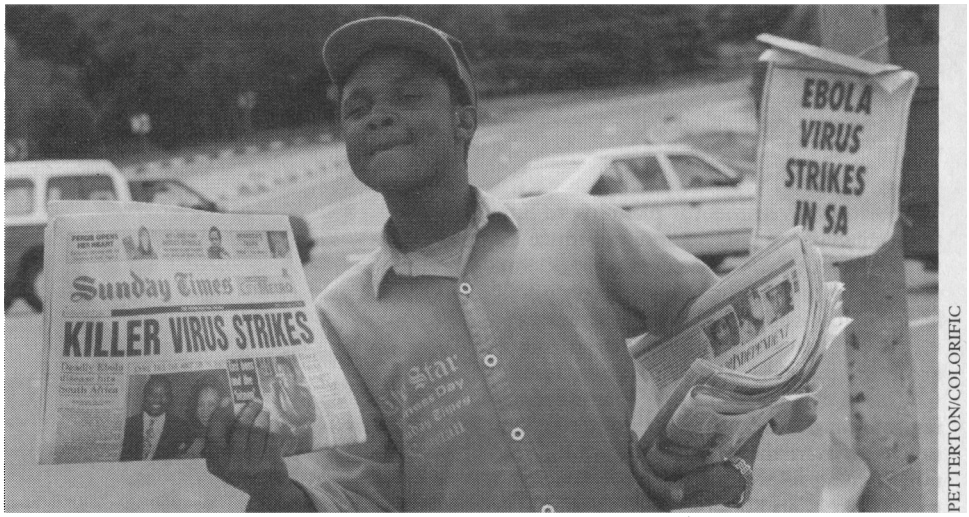
The doctor, Clement Mambana, who brought the virus into the country, has since recovered and returned home. He had flown to South Africa from Gabon when he could not diagnose and get appropriate treatment for his condition in his own country.

Flying sick patients from other African countries into South Africa is a growing commercial business involving medical rescue companies, airlines, civial aviation authorities private hospials and doctors. Dr Neil Cameron of South Africa's Department of Health said this was an area that needs regulating.

The problem was that existing regulations had been drawn up to deal with ports of entry when the mode of transport was sailing ships. Dr Cameron said there was a need for an early warning system so that port authorities were notified immediately if there was a problem. Port officials would then have to notify health suthorities as would the hospital receiving a patient. For highly infectious diseases patients may have to be referred to the few hospitals with the appropriate care to isolate them.

Other moves likely to be instituted as a result of the outbreak are attempts to increase awareness of various diseases (particularly the haemorrhagic fevers) and the setting up of a "hotline" through which information can be obtained and emergencies dealt with. Health authorities are talking to airlines and civil aviation authorities while considering further steps.

Dr Cameron said that 10 years ago an outbreak of Congo fever in Johannesburg had prompted authorities to put in place measures to cope with an outbreak of haemorrhagic fever, but these had since fallen away.—PAT SIDLEY, *medical journalist, Johannesburg*




PETTERTON/COLORIFIC

*The South African government is to set up a hotline to give out information about health scares*

# Widow's case raises issues of informed consent

The BMA was embroiled last week in the heated controversy over whether a young widow should be allowed to be conceive a baby with her dead husband's sperm.

The Human Fertilisation and Embryology Authority again rejected Diane Blood's plea for the right to take her husband's semen to Belgium or the United States, where she could be lawfully inseminated. Amid the outcry, it emerged that the chairman of the BMA's ethics committee had urged the authority not to change its mind only hours before it took its decision.

Doctors had taken the semen from 30 year old Stephen Blood at his wife's request as he lay in a coma 18 months ago after contracting meningitis. But the authority told her that it would be unlawful to use it in Britain as the Human Fertilisation and Embryology Act 1990 requires a man's written consent to the use of his sperm. Directions made by the authority ban the export of semen for a use that would be unlawful in Britain.

The authority refused to waive the rule, and the High Court upheld its decision last month, but the authority agreed to reconsider the issue, taking into account whatever extra information Mrs Blood wanted to provide. The chairman of the BMA's ethics committee, Stuart Horner, faxed his letter to the authority at 10 pm on Tuesday, 19 November, having learned from the authority that it was to consider Mrs Blood's plea at its Thursday afternoon meeting.

The letter was faxed by the authority to Mrs Blood's solicitors after 5 pm on Wednesday, and she was asked for a response by 1 pm Thursday, with the meeting scheduled for 2 pm. Dr Horner, who said that he wrote the letter after consulting with colleagues at the BMA, urged the authority not to change its mind. "We believe the doctrine of informed consent, which is central to medical ethics, must not be eroded," he wrote. "From the information which has been portrayed in the media, there is no evidence that Mr Blood had clearly thought through the issue and the full implications of a child being created after his death. Rather it appears that he made a passing comment whose validity is difficult to evaluate in retrospect. The special nature of genetic material, which is used to create new life, is of such fundamental importance that we believe it would be wrong to use the material without explicit informed consent."

Mrs Blood criticised Dr Horner for relying on media reports and for intervening in the case without seeing the evidence presented to the court and the authority. She said that her husband not only had remarked after reading an article about a similar case that he would like his sperm used in the event of his death but had been to see a financial adviser when the couple started trying for a baby about providing for a child in case he died.

Lord Winston, professor of fertility studies at the Hammersmith Hospital, London, who is backing Mrs Blood, said that she was a responsible woman with adequate financial support and a supportive family. He introduced his Human Fertilisation and Embryology (Amendment) Bill, in the House of Lords last week, saying that it would "remove the need for written consent to provision or use of gametes in certain circumstances." The bill gained a formal first reading but, without government support, which is unlikely to be forthcoming, it stands no chance of becoming law. Mrs Blood is appealing for funds to take her case to the Court of Appeal in January.—CLARE DYER, *legal correspondent, BMJ*

# Hospitals are accident hotspots

More than a million people a year are injured in accidents in English hospitals, the National Audit Office estimates. The immediate and long term costs of such accidents are likely to be at least £154m ($231m) a year.

The National Audit Office estimated that, on the basis of accidents recorded in 30 NHS acute trusts, there were likely to have been some 450 000 accidents in NHS acute hospital trusts in England during 1995. But because of underreporting of such accidents the true figure is probably considerably higher.

Three quarters of the accidents recorded in the survey affected patients or visitors to trusts, while the remaining quarter affected staff or contractors. For patients four fifths of the accidents were caused by slips, trips, and falls. For staff the main types of accidents were needlestick injuries; injuries caused during manual handling; slips, trips, and falls; and physical assaults by patients.

The inquiry is the first inside hospitals since the lifting in 1988 of Crown Immunity, which exempted hospitals from health and safety legislation.—JACQUI WISE, *BMJ*

• *Health and Safety in NHS Acute Hospital Trusts in England* is available from HMSO, price £8.95.

# Restrictions on paracetamol planned

The British government is planning to limit the availability of paracetamol to reduce the number of suicides and cases of accidental overdose with the drug. There are over 3000 hospital admissions each year in Britain as a result of poisoning through paracetamol, and more than 150 deaths from overdose.

The Medicines Control Agency is proposing to limit packs of paracetamol on general sale to no more than 12 (500 mg or 120 mg) tablets or capsules and to limit pharmacy sale to no more than 30 tablets or capsules. The agency said that this should be sufficient for short term treatment in minor self limiting illness, but if patients have chronic or recurrent conditions pharmacists may be able to sell multiple packs up to a maximum of 100 tablets or capsules. The agency is inviting comments from professional and consumer bodies and manufacturers on the proposals.

Dr John Henry, consultant physician at the medical toxicology unit at Guy's and St Thomas's Hospital Trust, welcomed the proposals. "There is evidence to suggest that the number of overdoses is related to the ready availability of tablets in large quantities. We consider that a restriction of analgesic pack size would help to reduce the number of serious overdoses," he said.

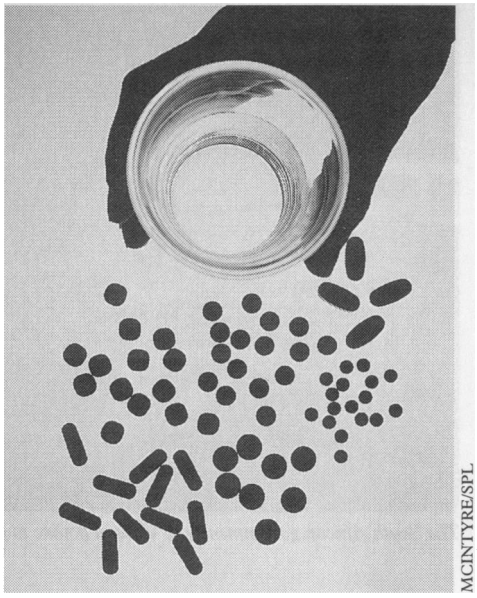
To prevent disparities between comparable analgesics, it is proposed that pharmacy packs of aspirin should be limited to 30 (325 mg) tablets and packs on general sale to 12 tablets. Packs of ibuprofen on general sale will remain unchanged but limited to 30 tablets from pharmacies.

Dr Henry said that overdose with ibuprofen has become more common since it became available over the counter in 1983, but cases of serious poisoning remain rare. "There are documented cases of patients taking very large numbers of tablets as a single dose with full recovery," he said. Aspirin is now used less frequently as an analgesic but is more likely to cause adverse effects and is more dangerous in overdose than either paracetamol or ibruprofen.

The proposals also state that products containing paracetamol should also carry an additional label warning stating: "Immediate advice should be sought in the event of an overdose even if you do not feel unwell." Patient leaflets should also carry the statement: "Immediate medical advice should be sought in the event of an overdose because of the risk of serious liver damage."

Health minister Gerald Malone said: "Analgesics are extremely safe and effective when used in the recommended doses and conditions. However, there are real concerns about the dangers of overdose. For example, with paracetamol the symptoms of overdose might not readily be apparent. This creates a risk that people might delay seeking medical help."

The Medicines Control Agency is inviting comments on the proposals until 10 January and hopes to implement any changes by April 1997.—JACQUI WISE, *BMJ*



MCINTYRE/SPL

*Paracetamol overdose kills over 150 people a year*

# Minister assures GPs over voluntary pilot studies

Participation in the different types of practice proposed in the white paper *Choice and Opportunity* (19 October, p 959) is voluntary and will remain so, Britain's health minister Gerald Malone emphasised to GPs last week.

Mr Malone was speaking at a special meeting of secretaries and chairmen of local medical committees in London in an attempt to allay fears that health authorities may set up pilots and that, like GP fundholding, some doctors might be pressurised into taking part. The voluntary nature, he said, would be enshrined in the National Health Service (Primary Care) Bill, which begins its passage through parliament next week.

He envisaged that most of the pilots of the different contracting arrangements would be led by doctors and trusts who wanted to do things in a different way; he saw little likelihood of supermarkets and drug companies wanting to participate. But it was not inconceivable that a group of GPs might get together in a corporate structure. The evaluation of the pilot schemes would not be a cursory glance by the secretary of state: the profession would be involved, he said.

To the suggestion that GPs' gatekeeper role and their ability to provide continuity of care were threatened by opening up primary care, Mr Malone said that the gatekeeper role was essential. "If we dismantle this we will unravel the service as a whole," he warned. He did not favour a health maintenance organisation model and said that whatever arrangements were adopted doctors and patients would be in exactly the same relationship as at present. There was no reason why doctors should not continue to act as advocates for their patients. And their clinical freedom would be unaffected whatever the setting.

One of the General Medical Services Committee's main worries about the white paper is the proposal to move general medical services from part II to part I of the NHS act, enabling any secretary of state to seek provision of general medical services from alternative sources, including the private sector. Reminded of the concern the minister said that there would be "no collective move to part I of the act."

The committee is also concerned that there will no longer be overriding control of staffing. The Medical Practices Committee has to take only existing pilot schemes into account when deciding on the allocation of doctors. There will be little new money for the initiative—the minister said that there would be £6m ($9m) for the pilot schemes. He hoped that the new proposals would be funded properly as the out of hours initiative had been. "This is something which we want to succeed, so there must be sufficient resources," he said.

The 34 clause bill is scheduled for a fast track through parliament, beginning in the House of Lords on 3 December, with the Commons stages early in the new year. More detailed regulations are to follow, so the first pilot schemes are not expected before 1 April 1998.—LINDA BEECHAM, *BMJ*

# Mentally ill people face discrimination

People with a mental health problem face widespread discrimination in many areas of life, including primary health care, according to a survey by the mental health charity MIND.

The survey, *Not Just Sticks and Stones*, found that half of those interviewed reported that they had been unfairly treated by health professionals because of their psychiatric history or current diagnosis. One third complained that their GPs had treated them unfairly, and the most common comment was that health care staff did not believe the patient's report of physical symptoms.

A frequent complaint was that physical symptoms were blamed too quickly, and in many cases wrongly, on the mental health problem. "Everything was put down to my mental health problem. I eventually received help when I was severely ill on holiday. This time I was immediately listened to and my problem diagnosed. This resulted in major abdominal surgery, much more severe than if it had been diagnosed earlier," said a 44 year old woman quoted in the report.

The survey, based on an analysis of 778 completed questionnaires, found that 34% of people with a mental health problem had been dismissed or forced to resign. Almost half, 47%, reported being abused or harassed in public, and 14% physically attacked. A quarter of those who took part said that they had been forced to move home.

The report comes on the eve of the implementation of the Disability Discrimination Act on 2 December (see p 1346), and MIND say the act's definitions are too narrow to protect people.—ROGER DOBSON, *medical journalist, Gwent*

# Gene may code for anxiety

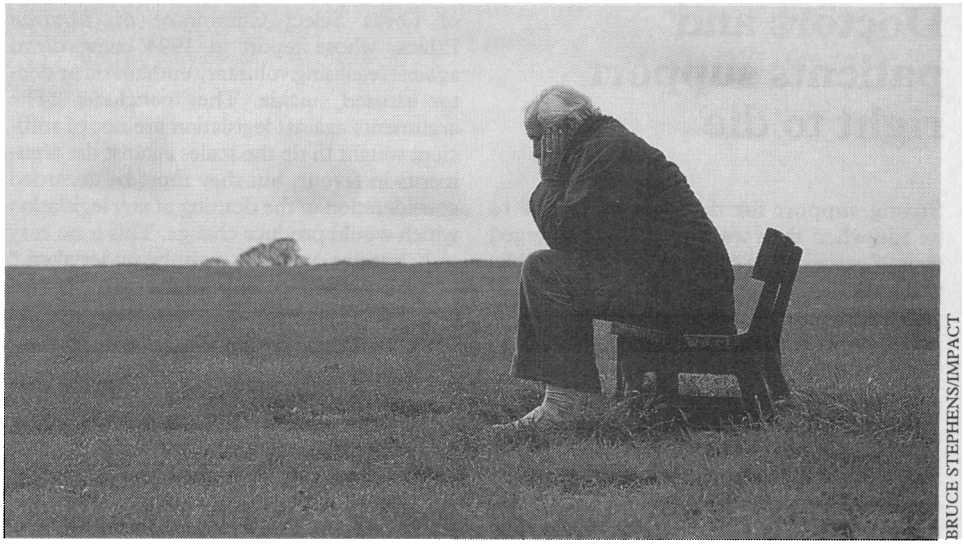
Scientists have found that variants of a certain gene contribute to different levels of anxiety in people. Although studies have shown that personality traits related to anxiety have a strong genetic component, this is the first time that any of the relevant genes have been identified.

A study of 550 people found that levels of neuroticism were correlated with two different alleles of the gene that encodes the protein that controls the levels of the neurotransmitter serotonin (*Science* 1996: 274:1527-30). The 5-HT transporter protein is well known to be linked with anxiety and depression and is the target of many antidepressants.

The longer allele of the transporter gene was associated with more neuroticism than the shorter allele. The authors postulate that this is because the longer allele is transcribed more efficiently than the shorter one, thereby producing more serotonin and leading to twice as much serotonin uptake.

The subjects, many of them siblings, underwent genotype analysis and three standard personality tests to evaluate personality traits. The results showed that the polymorphism of the serotonin transporter accounted for about 4% of variation in anxiety related traits among the individuals tested. The authors, from Würzburg in Germany and the National Institute of Mental Health in the United States, say that this is a small but none the less important genetic factor.

Unlike the clear cut genetic influence of some diseases, behavioural traits are thought to be affected by a complex array of environmental and physiological factors. Dr David Oldman from the National Institute on Alcohol Abuse and Alcoholism in Rockville, Maryland, commented that the research is an important approach for determining genetic factors in such behaviours and that the resulting knowledge should lead to better understanding as well as new tools for prevention and treatment.—JACQUI WISE, *BMJ*



BRUCE STEPHENS/IMPACT

*Could anxiety have a genetic link?*

# Unemployment quadruples among German doctors

Unemployment has quadrupled among German hospital doctors over the past 13 years, according to statistics presented last week to the Marburger Bund, Germany's representative organisation for hospital doctors. The worst affected are postgraduate hospital trainees and those working in regions belonging to the former West Germany.

The latest figures produced by Germany's central employment bureau show that at the end of 1995, 5800 trainees and 1900 fully trained specialists were registered unemployed. This figure includes 5400 postgraduate trainees in the states of the former West Germany alone. This represents a fourfold increase from 1982.

In the states of the former West Germany 1300 specialists are now unemployed, whereas in 1982 there were more positions than applicants for specialist posts. However, in the states of former East Germany only 400 trainees and 550 specialists are out of work.

Vacancies in east German hospitals have remained higher because of an exodus of hospital doctors into independent practice immediately after reunification, according to Dr Peter Jacobi, director of the central employment bureau. However, he warns that the situation is likely to worsen in the east, too, now that this trend has stabilised. Dr Jacobi says that part of the blame for the lack of hospital posts rests with the government's health service reforms. He said: "The uncertainty in planning in Germany's hospitals is at an all time high at present. Together with the capping of hospital budgets this is causing a noticeable reluctance to employ new staff."

None the less, unemployment remains lower for doctors than for other, comparable groups: just 3% of doctors are out of work compared with 5% of other university graduates. Of those doctors unemployed, fewer suffer long term unemployment than graduates in other disciplines, and the average age of those unemployed is also lower for doctors.

A critical time is the transition from preregistration to postregistration training, and it is at this stage of their careers that many young doctors are seeking work in Britain or Denmark, according to Dr Jacobi. "The situation is unlikely to improve in the short to medium term," he said.

Hospitals will need to restructure and doctors will need to learn new skills if the crisis is to be contained, Dr Jacobi argues. In particular he calls for greater flexibility in employment regulations, the dissolution of traditional hierarchies, and greater integration of wards and outpatient departments. He said that hospital doctors should take this opportunity to embrace new economic and managerial roles.—SANDRA GOLDBECKWOOD, *BMJ*

# Fetal retinal cells restore sight

Four blind patients have had their vision partially reconstituted with experimental fetal retinal cell transplants. The patients were all at the late stage of retinitis pigmentosa, a hereditary form of blindness for which no known cure exists. Although the work is preliminary, it is the first to show any potential for reversing the disease.

Eighteen patients have received such transplants so far. Dr Manuel del Cerro of the University of Rochester School of Medicine in New York presented the results of eight patients at the annual meeting of the Society of Neuroscience in Washington DC last week.

Retinal cells from aborted fetuses aged 14-16 weeks were used. About one million of these photoreceptor cells were microscopically implanted into the fovea of one eye in each patient. There was no evidence of immunorejection, infection, or inflammation in any of the implant recipients.

Positive results were achieved in four of the implant patients. The best result was in one recipient who went from no sight to "keyhole" vision. A further three patients displayed marginal improvements in light and motion detection. The implants took four to six months to take effect, and so far the improvements have remained stable. Patients were followed up with routine funduscopy, fluorescent angiography, and visual field testing. Dr del Cerro said that the research was preliminary. "We don't expect patients will recover a full field of vision," he added.

In the future Dr del Cerro hopes to pretreat the fetal cells with trophic factors. This is expected to increase the survival and potency of these cells and their ability to connect and communicate with host cells. He also expects to try transplants in patients at an earlier stage of their disease as those who had received the transplants were at an end stage of retinitis pigmentosa. Dr del Cerro's work was well received at the meeting but has not yet been published in a peer reviewed journal.—DEBORAH JOSEFSON, *Norwalk, Connecticut*

# Doctors and patients support right to die

Strong support for the right of adults to decide when they want to die has emerged from a survey of 986 members of the public and 1000 doctors and pharmacists. The survey forms part of a year long study of the issues surrounding doctor assisted suicide by Glasgow University's Institute of Law and Ethics in Medicine.

The report, by the institute's director, Professor Sheila McLean, and research fellow, Alison Britten, includes a "cautious" draft bill that the researchers call a "legislative template" for moving forward. The researchers also examined thoroughly the legal, ethical, and medical dilemmas surrounding the controversial issue.

The researchers disagree with the House of Lords Select Committee on Medical Ethics, whose report in 1994 came down against legalising voluntary euthanasia or doctor assisted suicide. They conclude: "The arguments against legislation are not of sufficient weight to tip the scales against the arguments in favour, but they must be accorded consideration in the drafting of any legislation which would produce change. This is no easy task, but one on which must be undertaken."

In a sample of 986 adults, 80% agreed with the statement: "Human beings should have the right to choose when to die." A striking finding was that most preferred voluntary euthanasia (42%) to assisted suicide (28%), while doctors preferred physician assisted suicide (43%) to voluntary euthanasia (19%).

It seems, therefore, that neither doctors nor patients wanted to take the main responsibility: in voluntary euthanasia the patient decides to die but the doctor, friend, or relative does the act that ends the patient's life, whereas in assisted suicide the doctor only helps the patient to take his or her own life.

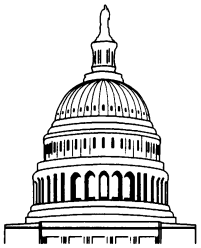
Nearly 50% of doctors wanted a change in the law, with few differences in the percentage of GPs, surgeons, hospital doctors, or psychiatrists. But pharmacists (72%) and anaesthetists (56%) were more strongly in favour.

The Voluntary Euthanasia Society has also produced a draft bill, the Physician Assisted Suicide Bill, published in full in a recent edition of the *Bulletin of Medical Ethics* (1996:**121**:19-22). The bill would "enable a person who is suffering distress as a result of his terminal illness or incurable physical condition to request assistance from a physician to end his life."

A patient with a terminal illness or incurable condition diagnosed by two doctors, including a consultant in the illness, would be able to request assisted suicide if the effect was "physical or mental distress which he is unwilling to bear." The patient would have to have signed two request forms for assistance and not asked later for either to be cancelled.—CLARE DYER, *legal correspondent, BMJ*

## *Focus: Washington*

# Controversy surrounds home monitoring and diagnosis



Over the past 20 years home monitoring of medical conditions has proliferated in the United States, but the growth now is creating criticism from both patient groups and doctors. Home monitoring began with the support of doctors. They believed that when patients monitor their own health progress they have goals to aim at, thus increasing compliance with medical regimens.

The first monitoring was innocuous—thermometers to gauge the effects of antibiotics and bathroom scales to monitor the effects of treatment for congestive heart failure. Then came home glucose monitors, relatively inexpensive kits (less than $100; £70) that help diabetic patients to adjust their own insulin. Home pregnancy kits have become a staple item for many Americans seeking to become pregnant, and kits that detect ovulation are critical to successful conception for couples with infertility problems.

Despite the undoubted benefit of these tests, newer home health monitoring devices have raised questions. Many Americans now monitor their cholesterol concentration and blood pressure at home, and some doctors report that patients check their levels much too often causing undue anxiety.

But true public debate over home monitoring opened this year with the introduction of two new home tests.

The first of these was home testing for HIV infection. This spring the US Food and Drug Administration allowed the marketing of two such tests, one by the pharmaceutical company Johnson and Johnson and another by Home Access Health Corporation. The kits cost about $40, and they are not so far truly home test kits. They are bought at pharmacies and include a blood lancet and a paper blotter to collect the sample. The blotter is sent to a central laboratory, along with an anonymous identification number, and the results are available on a telephone recording within three business days.

Many HIV activists have opposed this method of testing. They say that people should receive the test results in person from a health professional, not a telephone recording. Furthermore, even though the recordings given to those with a negative result describe the need to use caution in sexual practices and explain the window between infection and antibody production, the critics claim that most people, on hearing that their result is negative, will simply hang up before the six minute recording has run.

But public health leaders say that at least 60% of Americans at risk of HIV infection, an estimated 30 million people, have not been tested. Officials from Johnson and Johnson say that the $40 price tag is not too high for poorer Americans, who are at highest risk of infection. During early marketing tests in Florida and Texas, both Afro-American and Hispanic people bought tests far out of proportion to their numbers in the population. And 85% of those whose result was negative did listen to the entire educational recording.

The second home test to receive widespread criticism is the home drug test that is marketed to parents of adolescents. American parents are extremely concerned with drug use among their children—some have even taken their children to hospital emergency departments for mandatory drug tests, at a cost of up to $1000. One such parent, high school teacher Sunny Cloud of Atlanta, began to sell a home drug test costing about $40 that detects marijuana, barbiturates, cocaine, amphetamines, phencyclidine, opiates, and benzodiazepines. As with the HIV home test, the specimen (in this case, urine) is sent to an approved laboratory, and confidentiality is maintained through coded identification numbers.

The Food and Drug Administration has objected to the test, saying that it has not met the agency's approval for home medical tests. Supporters maintain, however, that the test is identical to those already approved for and in use by employers, sports organisations, and even the federal government. And leaders in Congress are apparently lobbying the administration to allow use of home tests.

But the administration does have the support of the medical community. Richard Heyman, chairman of the American Academy of Pediatrics' committee on substance abuse, told the American Medical Association that the test "is an inappropriate way to do detection work."

The results may be inaccurate because the child may give a false urine sample if unobserved and parents may have a false sense of security. Perhaps more dangerous are the problems with false positive results, which could result in unfair punishment, perhaps even child abuse. Moreover, the test only detects drug use. It does not diagnose the cause, which may include depression, anxiety disorders, or attention deficit disorder.—JOHN ROBERTS, *Washington*